

EAP Clinician Profile

Date of Application:	
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Contact Information

Business Name:					
Address:					
City:		State:		Zip:	
Last Name:			First Name:		
Gender:			Race(Optional)		
Phone:			Cell Phone:		
Email:				Date of Birth:	

Employee Assistance Counseling Experience

I have at least ONE year experience providing Employee Assistance Counseling.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total Number of Years providing EAP Services		
If Yes, please list the names of the EAP Networks for which you provide Services.		
If No EAP Experience, I understand that I will be required to attend an FEI EAP Teleconference.		

Practice Information:

Assess/Refer children 5 yrs of age and up with their parents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
After providing an EAP Assessment, you may need to make a referral for a client, are you familiar with local community resources available for clients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you provide Faith Based Counseling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you see clients in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you HIPPA compliant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you provide a cultural or ethnic specialty in your practice? (Check all that apply)

<input type="checkbox"/> African American	<input type="checkbox"/> Asians	<input type="checkbox"/> Gay/Lesbian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Holocaust Survivors	<input type="checkbox"/> Native American
<input type="checkbox"/> Vietnam Veterans	<input type="checkbox"/> Veterans	
<input type="checkbox"/> Other (please specify)		

Please identify your areas of specialization: (check all that apply)

<input type="checkbox"/> Adjustment issues	<input type="checkbox"/> Financial Issues
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Marital Issues
<input type="checkbox"/> Anxiety Issues	<input type="checkbox"/> CISD/CISM
<input type="checkbox"/> Bereavement Issues	<input type="checkbox"/> Parent/Child Issues
<input type="checkbox"/> Childhood/ Adolescent Issues	<input type="checkbox"/> Phase of Life Transition
<input type="checkbox"/> Depression/Affective Disorders	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Domestic Abuse	<input type="checkbox"/> Relationship/Interpersonal
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Separation/Divorce
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Educational/Learning Issues	<input type="checkbox"/> Stress
<input type="checkbox"/> Family Issues	<input type="checkbox"/> Work Place Issues <input type="checkbox"/> Other:

To Receive Specialty Referrals Complete the Following:

Do you have experience providing EAP Orientations/Trainings? If yes complete the Trainer app: http://www.feinet.com/app.htm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have experience providing Critical Incident Stress Debriefings? If yes complete the Trauma app: http://www.feinet.com/app.htm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have experience treating Alcohol & Substance Abuse? If yes complete the SA app: http://www.feinet.com/app.htm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a Certified Employee Assistance Professional (CEAP)? Please provide a copy of certification including expiration date	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please indicate which insurance panels you are a member of:

<input type="checkbox"/> Aetna	<input type="checkbox"/> First Health	<input type="checkbox"/> Kaiser Permanente	<input type="checkbox"/> Pacific Care	<input type="checkbox"/> Value Options
<input type="checkbox"/> APHealthcare	<input type="checkbox"/> Guardian	<input type="checkbox"/> Magellan	<input type="checkbox"/> Prudential	<input type="checkbox"/> Wausau
<input type="checkbox"/> BCBS	<input type="checkbox"/> Humana	<input type="checkbox"/> Managed Health Network	<input type="checkbox"/> Tri Care	<input type="checkbox"/> WEA
<input type="checkbox"/> Cigna	<input type="checkbox"/> Horizon	<input type="checkbox"/> Oxford	<input type="checkbox"/> UBH	<input type="checkbox"/> WPS

Agreement

I hereby certify that all of the responses and information provided pursuant to the above are complete, true, and correct, to the best of my knowledge.

Signature:	
Title:	
Date:	